DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

ce for jt

PRINTED: 01/21/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155443	A. BUILDING 01 B. WING _____	01/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERS OF MUNCIE, THE	2400 CHATEAU DRIVE MUNCIE, IN 47303

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 01/12/10 Facility Number: 000310 Provider Number: 155443 AIM Number: 100288970 Surveyor: Phillip Komsiski, Life Safety Code Specialist At this Life Safety Code survey, The Waters of Muncie was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors. The resident rooms have battery powered smoke detection. The facility has a capacity of 72 and had a census of 62 at the time of this survey. Quality Review by Robert Booher, REHS, Life Safety Code Specialist-Medical Surveyor on 01/20/11. The facility was found not in compliance with the aforementioned regulatory requirements as	K 000	Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission or agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with State and Federal laws. RECEIVED FEB - 3 2011 LONG TERM CARE DIVISION INDIANA STATE DEPARTMENT OF HEALTH ENTERED FEB 4 2011	

APPROVED
2/8/11 DA

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Christopher Jamison H.F.A	Administrator	1-31-11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155443	A. BUILDING 01 B. WING _____	01/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERS OF MUNCIE, THE	2400 CHATEAU DRIVE MUNCIE, IN 47303

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 evidenced by the following:	K 000		
K 017 SS=B	NFPA 101 LIFE SAFETY CODE STANDARD Corridors are separated from use areas by walls constructed with at least ½ hour fire resistance rating. In sprinklered buildings, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls properly extend above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to the corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.) 19.3.6.1, 19.3.6.2.1, 19.3.6.5 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure 1 of 1 open use areas were separated from the corridor or met an Exception. LSC 19.3.6.1, Exception # 1, Spaces shall be permitted to be unlimited in area and open to the corridor, provided the following criteria are met: (a) The spaces are not used for patient sleeping rooms, treatment rooms, or hazardous areas. (b) The corridors onto which the spaces open in the same smoke compartment are protected by an electrically supervised automatic smoke detection system in accordance with 18.3.4, or the smoke compartment in which the space is located is protected throughout by quick-response	K 017	**K 017** **What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?** No resident, visitor or staff were found to be affected by the alleged deficient practice. **How will you identify other residents having the potential to be affected by the same alleged deficient practice and what corrective action will be taken?** Any resident could have the potential to be affected by the alleged deficient practice. Licensed Contractor installed a smoke detector in the Reception Office. **What measures will be put into place or what systemic changes you will make to ensure that the alleged deficient practice does not recur?** Facility Maintenance Director/designee will monitor smoke detectors monthly as part of the Preventative Maintenance Program.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155443	A. BUILDING 01 B. WING _____	01/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERS OF MUNCIE, THE	2400 CHATEAU DRIVE MUNCIE, IN 47303

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 017	Continued From page 2 sprinklers. (c) The open space is protected by an electrically supervised automatic smoke detection system in accordance with 18.3.4, or the entire space is arranged and located to allow direct supervision by the facility staff from a nurses' station or similar space. (d) The space does not obstruct access to required exits. This deficient practice could affect 3 residents observed lounging by the front Reception office as well as visitors and staff. Findings include: Based on observation on 01/12/11 at 10:44 a.m. with the Director of Nursing (DON), the sliding glass doors installed at the front Reception office were not self closing and were open to the front entrance corridor. Exception # 1, requirement (c) of the Life Safety Code, Chapter 19.3.6.1 was not met as follows: the open area was not protected by an automatic smoke detection system or arranged to allow direct supervision by facility staff from a continuously staffed area such as a nurses' station. Based on interview on 01/12/11 at 10:47 a.m. with the DON, it was acknowledged the front Reception office was open to the entry corridor without supervision from the nurse's station and was not protected by automatic smoke detection.	K 017	**How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** Monthly Maintenance Program documentation will be reviewed by the QA Committee during monthly QA Meetings to ensure completion and appropriate follow-up. **Compliance date:** This plan of correction constitutes our allegation of compliance with all regulatory requirements. Our date of compliance is 2/11/11	
K 018 SS=E	3.1-19(b) NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only	K 018	**K 018** **What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?** No resident, visitor or staff were found to be affected by the alleged deficient practice.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155443	A. BUILDING 01 B. WING _____	01/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERS OF MUNCIE, THE	2400 CHATEAU DRIVE MUNCIE, IN 47303

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 018	Continued From page 3 required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure 1 of 12 corridor doors on 200 hall and 3 of 14 corridor doors on 400 hall would latch into their frames. This deficient practice could affect 23 residents on 200 hall and 25 residents on 400 hall including visitors and staff. Finding include: Based on observations on 01/12/11 during the tour between 12:00 p.m. and 2:00 p.m. with Director of Nursing (DON) and interim Maintenance Supervisor, rooms 207, 404, 408, and 409 did not latch into their frames. Based on interview on 01/12/11 concurrent with the observations, the DON and interim Maintenance Supervisor acknowledged the aforementioned doors would not latch into their frames. 3.1-19(b)	K 018	**How will you identify other residents having the potential to be affected by the same alleged deficient practice and what corrective action will be taken?** Any resident could have the potential to be affected by the alleged deficient practice. The doors to rooms 207, 404, 408 and 409 have been repaired and now latch. A 100% audit of all doors was conducted to ensure all doors fully latch. Any necessary repairs were made. **What measures will be put into place or what systemic changes you will make to ensure that the alleged deficient practice does not recur?** Maintenance Director/designee will audit doors monthly to ensure all doors close and latch completely. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** Results of monthly audits will be reviewed by QA Committee during	
K 038	NFPA 101 LIFE SAFETY CODE STANDARD	K 038		

K 018 Continued
monthly QA Meetings to ensure completion and appropriate follow-up.

Compliance date:
This plan of correction constitutes our allegation of compliance with all regulatory requirements. Our date of compliance is 2/11/11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155443	A. BUILDING 01 B. WING _____	01/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERS OF MUNCIE, THE	2400 CHATEAU DRIVE MUNCIE, IN 47303

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 038 SS=E	Continued From page 4 Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: 1. Based on observation and interview, the facility failed to ensure 1 of 3 exits with ramps was provided with handrails on at least one side. LSC Section 7.2.2.4.2 requires stairs and ramps shall have handrails on both sides. Exception # 3 allows existing ramps to be permitted to have a handrail on one side only. Handrails shall be provided within 30 inches of all portions of the required egress width of stairs. This deficient practice could affect 24 residents on 300 hall including staff, and visitors if the facility were required to evacuate in an emergency. Findings include: Based on observation on 01/12/11 at 1:05 p.m. with the Director of Nursing (DON) and interim Maintenance Supervisor the exit discharge ramp for 300 hall had a measured slope of three inches per two feet of walkway. Based on interview on 01/12/11 at 1:10 p.m. with the DON and interim Maintenance Supervisor, it was acknowledged the slope measurement was accurate and there were no handrails provided on either side of the ramp. 3.1-19(b) 2. Based on observation and interview, the	K 038	**K 038** **What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?** No resident, visitor or staff were found to be affected by the alleged deficient practice. **How will you identify other residents having the potential to be affected by the same alleged deficient practice and what corrective action will be taken?** Any resident, visitor or staff could have the potential to be affected by the alleged deficient practice. 1. Handrails were installed at the 300 Hall exit discharge ramp. 2. The cement walkway at the 400 Hall exit was replaced. **What measures will be put into place or what systemic changes you will make to ensure that the alleged deficient practice does not recur?** 1. Maintenance Director/designee will audit the handrails monthly as	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155443	A. BUILDING 01 B. WING _____	01/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERS OF MUNCIE, THE	2400 CHATEAU DRIVE MUNCIE, IN 47303

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 038	Continued From page 5 facility failed to ensure exit access was arranged so 1 of 10 exits were readily accessible at all times in accordance with LSC Section 7.1. LSC Section 7.1.10.1 requires means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency This deficient practice could affect 25 residents on 400 hall including visitors and staff in the facility. Findings include: Based on observation on 01/12/11 at 12:22 p.m. with the Director of Nursing (DON) and interim Maintenance Supervisor, the cement walkway used to discharge 400 hall residents was cracked and partly in rubble at the threshold of the exit. Based on interview on 01/12/11 at 12:25 p.m. with the DON and interim Maintenance Supervisor it was acknowledged the concrete threshold just outside the 400 hall exit was cracked with rubble creating an uneven surface for residents to walk on while evacuating the building. 3.1-19(b)	K 038	part of the Monthly Preventive Maintenance Program. 2. Maintenance Director/designee will audit the cement walkways monthly as part of the Monthly Preventive Maintenance Program. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** Results of the monthly Preventative Maintenance Rounds will be reviewed by QA Committee during monthly QA Meetings to ensure completion and appropriate follow-up. **Compliance date:** This plan of correction constitutes our allegation of compliance with all regulatory requirements. Our date of compliance is 2/11/11.	
K 046 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to provide documentation of functional tests on all emergency lighting for 10 of 10 battery operated exterior lights and 1 of 1 lights at the generator. NFPA 110, 5-3-1 requires lighting at the emergency generator. LSC Section 7.9.3	K 046	**K 046** **What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?** No resident, visitor or staff were found to be affected by the alleged deficient practice.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155443	A. BUILDING 01 B. WING _____	01/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERS OF MUNCIE, THE	2400 CHATEAU DRIVE MUNCIE, IN 47303

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 046	Continued From page 6 requires a functional test be conducted on every required emergency lighting system at 30 day intervals for not less than 30 seconds and an annual test for not less than 1 1/2 hours. This deficient practice could affect all occupants in the facility including staff, visitors and residents if the generator was impaired and there was no functional emergency battery powered light available. Findings include: Based on Fire Safety Record review on 01/12/11 at 1:33 p.m. with the Director of Nursing (DON) and interim Maintenance Supervisor the facility tested the battery back up emergency lights for all the exits and generator monthly, but did not document any length of time. In addition, a 90 minute annual test was not available for review. Based on interview on 01/12/11 at 1:35 p.m. with the DON and interim Maintenance Supervisor it was acknowledged the outside battery back up emergency lights and generator light were checked monthly, but no documentation for the duration of the monthly or annual test was available for review. 3.1-19(b)	K 046	**How will you identify other residents having the potential to be affected by the same alleged deficient practice and what corrective action will be taken?** Any resident, visitor or staff could be affected by the alleged deficient practice. A 100% audit of all emergency lighting was performed to ensure emergency lighting meets the standard. Repairs were made as necessary. The Maintenance Director was in-serviced by Corporate Property Manager, on proper documentation of emergency lighting audits. **What measures will be put into place or what systemic changes you will make to ensure that the alleged deficient practice does not recur?** The Maintenance Director/designee will monitor emergency lighting and document results monthly with Preventative Maintenance program. **How the corrective action(s) will be monitored to ensure the**	
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by:	K 062		

K 046 Continued
deficient practice will not recur, i.e., what quality assurance program will be put into place?
Results of the monthly Preventative Maintenance Program audits will be reviewed by QA Committee during monthly QA Meetings to ensure completion and proper follow-up.

Compliance date:
This plan of correction constitutes our allegation of compliance with all regulatory requirements. Our date of compliance is 2/11/11.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155443	A. BUILDING 01 B. WING _____	01/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERS OF MUNCIE, THE	2400 CHATEAU DRIVE MUNCIE, IN 47303

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 062	Continued From page 7 Based on record review and interview, the facility failed to ensure 1 of 1 dry automatic sprinkler piping systems was maintained in reliable working condition as required by NFPA 25, the Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems 10-2.1. This deficient practice affects all occupants. Findings include: Based on review of sprinkler system test reports on 01/12/11 at 3:02 p.m. with the interim Maintenance Supervisor, documentation to indicate an internal inspection of the sprinkler system pipes had been done could not be found. Based on interview on 01/12/11 at 3:04 p.m. with the interim Maintenance Supervisor, it was acknowledged the facility was unaware an internal sprinkler pipe inspection had ever been done and they have not scheduled a date to have the work done. 3.1-19(b)	K 062	**K 062** **What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?** No occupant was found to be affected by the alleged deficient practice. **How will you identify other residents having the potential to be affected by the same alleged deficient practice and what corrective action will be taken?** Any occupant could have the potential to be affected by the alleged deficient practice. Complete internal pipe inspection was completed and documented. **What measures will be put into place or what systemic changes you will make to ensure that the alleged deficient practice does not recur?** The Maintenance Director/designee will monitor all quarterly Sprinkle Inspections to ensure the system meets the standards.	
K 068 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Combustion and ventilation air for boiler, incinerator and heater rooms is taken from and discharged to the outside air. 19.5.2.2 This STANDARD is not met as evidenced by: Based on observations and interview, the facility failed to ensure 3 of 3 boiler/mechanical rooms was provided with intake combustion air from the outside for rooms containing fuel fired equipment in accordance with LSC Section 19.5.2.2. This deficient practice could create an atmosphere rich	K 068		

K 062 Continued
How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?
Results of the quarterly Sprinkler Inspection will be reviewed by the QA Committee, quarterly at the QA Meeting to ensure completion and proper follow-up.

Compliance date:
This plan of correction constitutes our allegation of compliance with all regulatory requirements. Our date of compliance is 2/11/11.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155443	A. BUILDING 01 B. WING _____	01/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERS OF MUNCIE, THE	2400 CHATEAU DRIVE MUNCIE, IN 47303

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 068	Continued From page 8 with carbon monoxide which could cause physical problems for 11 residents on 100 hall, 10 residents in the dining room which is next to the Laundry room and 7 residents in the 300 hall lounge which is next to the Maintenance shop including visitors and staff. Findings include: Based on observations on 01/12/11 during the tour between at 11:57 a.m. to 1:15 p.m. with the Director of Nursing (DON) and interim Maintenance Supervisor, the 100 hall utility room, the service hall Laundry room and the 300 hall Maintenance room each had one fuel fired boiler with no fresh air intake. Based on interview on 01/12/11 concurrent with the observations, it was acknowledged by the DON and interim Maintenance Supervisor the aforementioned rooms with fuel fired boilers did not have fresh air intakes.	K 068	**K 068** **What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?** No resident, staff or visitor was found to be affected by the alleged deficient practice. **How will you identify other residents having the potential to be affected by the same alleged deficient practice and what corrective action will be taken?** Any resident, visitor or staff could be affected by the alleged deficient practice. Fresh air intakes have been installed to all fuel fired boilers. **What measures will be put into place or what systemic changes you will make to ensure that the alleged deficient practice does not recur?** The Maintenance Director/designee will monitor all fresh air intakes monthly for proper function as part of the monthly Preventative Maintenance Program.	
K 143 SS=E	3.1-19(b) NFPA 101 LIFE SAFETY CODE STANDARD Transferring of oxygen is: (a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction; (b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and (c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance	K 143		

K 068 Continued
How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?
Monthly Preventative Maintenance audits will be reviewed by QA Committee in monthly QA Meeting to ensure completion and appropriate follow-up.

Compliance date:
This plan of correction constitutes our allegation of compliance with all regulatory requirements. Our date of compliance is 2/11/11.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155443	A. BUILDING 01 B. WING _____	01/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERS OF MUNCIE, THE	2400 CHATEAU DRIVE MUNCIE, IN 47303

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 143	Continued From page 9 with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2 This STANDARD is not met as evidenced by: 1. Based on observation and interview, the facility failed to ensure 1 of 1 oxygen storage rooms had a sign posted indicating oxygen transferring was occurring in the oxygen storage rooms. This deficient practice could affect 22 residents on 300 hall including visitors and staff near the oxygen storage room. Findings include: Based on observation on 01/12/11 at 1:45 p.m. with the interim Maintenance Supervisor, the oxygen transfer room on 300 hall where liquid oxygen containers were stored and used to transfill oxygen, lacked a sign posted on the oxygen storage room door indicating the transfer of oxygen was being conducted at this site. Based on interview on 01/12/11 at 1:47 p.m. with the interim Maintenance Supervisor, it was acknowledged oxygen transfers takes place but a sign to indicate such conduct was not posted on the door or available anywhere else in the facility. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 1 oxygen storage rooms where oxygen transferring was occurring was separated within a one hour fire barrier enclosure. This deficient practice could affect 22	K 143	**K 143** **What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?** No resident, visitor or staff were found to be affected by the alleged deficient practice. **How will you identify other residents having the potential to be affected by the same alleged deficient practice and what corrective action will be taken?** Any resident, visitor or staff could be affected by the alleged deficient practice. 1. Signage has been posted on the oxygen transferring room to indicate oxygen transfer occurring. 2. A new door with a fire rated information on tag has been installed on the oxygen transferring room. **What measures will be put into place or what systemic changes you will make to ensure that the**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155443	A. BUILDING 01 B. WING _____	01/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERS OF MUNCIE, THE	2400 CHATEAU DRIVE MUNCIE, IN 47303

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 143	Continued From page 10 residents on 300 hall including visitors and staff near the oxygen storage room. Findings include: Based on observation on 01/12/11 at 1:48 p.m. with the interim Maintenance Supervisor, a fire rated tag could not be found on the corridor door to the oxygen transfer room on 300 hall indicating it was a forty five minute fire rated door. Based on interview on 01/12/11 at 1:50 p.m. with the interim Maintenance Supervisor, it was confirmed a tag on the oxygen storage room door was not present and no other documentation was available to identify the door as a forty five minute fire rated door. 3.1-19(b)	K 143	**alleged deficient practice does not recur?** The Maintenance Director/designee will audit the oxygen room monthly for appropriate signage and fire door rating as part of the monthly Preventative Maintenance Program. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** Results of the monthly Preventative Maintenance audits will be reviewed by the QA Committee during monthly QA Meetings to ensure completion and appropriate follow-up. **Compliance date:** This plan of correction constitutes our allegation of compliance with all regulatory requirements. Our date of compliance is 2/11/11.	
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: 1. Based on observation, record review and interview; the facility failed to ensure 1 of 1 emergency generators was equipped with remote manual stops. LSC 7.9.2.3 requires emergency generators providing power to emergency lighting systems shall be installed, tested and maintained	K 144		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155443	A. BUILDING 01 B. WING _____	01/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERS OF MUNCIE, THE	2400 CHATEAU DRIVE MUNCIE, IN 47303

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 144	Continued From page 11 in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. NFPA 110, 1999 edition, 3-5.5.6 requires Level II installations shall have a remote manual stop station of a type similar to a break-glass station located elsewhere on the premises where the prime mover is located outside the building. NFPA 37, Standard for the Installation and Use of Stationary Combustion Engines and Gas Turbines, 1998 Edition, at 8-2.2(c) requires engines of 100 horsepower or more have provision for the shutting down the engine at the engine and from a remote location. This deficient practice could affect all occupants. Findings include: Based on review of the Generator Maintenance records on 01/12/11 at 2:30 p.m. with the interim Maintenance Supervisor, there was no documentation available which indicated the amount of horsepower the generator was provided. Based on observation of generator equipment on 01/12/11 2:15 p.m. with the interim Maintenance Supervisor, no evidence of a remote shut off device was found for the generator, furthermore, the interim Maintenance Supervisor indicated he was not sure if either generator was 100 horsepower or more, and there was no information on the generator to indicate what the horsepower was. Based on interview at 2:25 p.m., the interim Maintenance Supervisor indicated he was not aware of a remote shut off device for the generator, and the interim Maintenance Supervisor indicated the generator was installed before 2003. 3.1-19(b)	K 144	**K 144** **What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?** No occupant was found to be affected by the alleged deficient practice. **How will you identify other residents having the potential to be affected by the same alleged deficient practice and what corrective action will be taken?** Any occupant could be affected by the alleged deficient practice. The facility generator is 50kw. 50kw is 67HP which falls under the requirement of 100HP to require remote shut off. Documentation has been recorded in the Generator Log Book to show calculations. **What measures will be put into place or what systemic changes you will make to ensure that the alleged deficient practice does not recur?** The Maintenance Director has been in-serviced on weekly and monthly	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155443	A. BUILDING 01 B. WING _____	01/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERS OF MUNCIE, THE	2400 CHATEAU DRIVE MUNCIE, IN 47303

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 144	Continued From page 12 2. Based on record review and interview, the facility failed to exercise the generator for 12 of 12 months to meet the requirements of NFPA 110, the Standard for Emergency and Standby Powers Systems, chapter 6-4.2. NFPA 99, the Standard for Health Care Facilities, Nursing Home requirements requires essential electrical distribution systems to conform to Type 2 systems as described in Chapter 3 of NFPA 99. Chapter 3-4.4.1.1 of NFPA 99 requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA electrical system to be in accordance with NFPA 110. Chapter 6-4.2 of NFPA 110 requires generator sets in Level 1 and Level 2 service to be exercised at least once monthly, for a minimum of thirty minutes, using one of the following methods: a. Under operating temperature conditions or at not less than 30 percent of the EPS nameplate rating. b. Loading which maintains the minimum exhaust gas temperatures as recommended by the manufacturer. The date and time of day for required testing shall be decided by the owner, based on facility operations. This deficient practice could affect all residents staff and visitors. Findings include: Based on review of Generator System Testing records and Maintenance logs on 01/12/11 at 2:38 p.m. with the interim Maintenance Supervisor, there was no documentation which verified the the amperage or the percentage of load capacity for the past twelve months. Based on interview on 01/12/11 at 2:40 p.m. with the	K 144	generator load testing by Corporate Property Manager. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The QA Committee will review Generator Log Book during monthly QA Meeting to ensure completion and appropriate follow-up. **Compliance date:** This plan of correction constitutes our allegation of compliance with all regulatory requirements. Our date of compliance is 2/11/11.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155443	A. BUILDING 01 B. WING _____	01/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERS OF MUNCIE, THE	2400 CHATEAU DRIVE MUNCIE, IN 47303

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 144	Continued From page 13 interim Maintenance Supervisor, it was acknowledged the facility had no documentation to verify amperage or percentage of load capacity for the generator for the past twelve months. 3.1-19(b)	K 144		
K 154 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1 This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to protect 62 of 62 residents by providing a complete written policy containing procedures to be followed in the event the automatic sprinkler system has to be placed out of service for more than 4 hours in a 24 hour period in accordance with LSC, Section 9.7.6.1. LSC 9.7.6.2 requires sprinkler impairment procedures comply with NFPA 25, Standard for Inspection, Testing and Maintenance of Water Based Fire Protection Systems. NFPA 25, 11-2 requires an appointed sprinkler impairment coordinator. NFPA 25, 11-5 requires a preplanned program to include evacuation or an approved fire watch and 11-5(d) requires the local fire department be notified of a sprinkler impairment and 11-5(e) requires the insurance carrier, alarm company, building owner/manager and other authorities having	K 154	**K 154** **What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?** No resident, visitor or staff were found to be affected by the alleged deficient practice. **How will you identify other residents having the potential to be affected by the same alleged deficient practice and what corrective action will be taken?** Any resident, visitor or staff could be affected by the alleged deficient practice. The written policy for an impaired sprinkler system has been modified to meet the standard. **What measures will be put into place or what systemic changes you will make to ensure that the alleged deficient practice does not recur?** The QA Committee will review the Impaired Sprinkler Policy at next QA Meeting to ensure proper completion of modification.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155443	A. BUILDING 01 B. WING _____	01/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERS OF MUNCIE, THE	2400 CHATEAU DRIVE MUNCIE, IN 47303

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 154	Continued From page 14 jurisdiction also be notified and 11-5(f) requires notification of supervisors in the area in addition to those already mentioned and lastly 11-7 requires notification of everyone again when the system is restored. This deficient practice could affect all residents, staff and visitors. Findings include: Based on Sprinkler record review on 01/12/11 at 3:05 p.m. with the interim Maintenance Supervisor, the facility did have a written policy and procedure for an impaired sprinkler system available for review, but it did not address notifying all entities again once the sprinkler system has been restored to normal. Based on interview on 01/12/11 at 3:06 p.m. with the interim Maintenance Supervisor, it was acknowledged the fire watch policy did not include notifying all entities again once the sprinkler system had been restored to normal operation. 3.1-19(b)	K 154	**How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The facility QA Committee will review facility policies annually to ensure compliance. **Compliance date:** This plan of correction constitutes our allegation of compliance with all regulatory requirements. Our date of compliance is 2/11/11.	